Texas Department of Insurance
Division of Workers' Compensation
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address:

Respondent Name:
ASSOC CASUALTY INSURANCE CO

Carrier's Austin Representative Box
Box Number 53

MFDR Tracking Number:
M4-12-2558-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "I have faxed in the form DWC060 filled out, a copy from Hope Pharmacy and Meijer Pharmacy of the perscriptions [sic] that I paid for that the insurance was suppose to pay for and denied it (as they were found in court to be responsible for any medical treatment and perscriptions [sic] that I needed for the injury that I sustained at work). I also am faxing in the denial letter that the insurance sent me stating that they were not gonna pay for the perscriptions [sic] and the original fax that I sent the insurance company requesting payment. Last I am sending in a copy of a EMG that I had done on April 3, 2012 showing that I have nerve damage causing my pain from my back down to my left leg and is chronic so this should prove that I indeed need all the medicines that are prescribed to be by my doctor.

Amount in Dispute: $676.76

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: Enclosed please find peer reviews regarding this Claimant, including the peer review of Terry Troutt, M.D. who opined on 05-11-10 that the continued use of prescription analgesics is not responsible or medically necessary. Dr. Troutt recommended a weaning process regarding the use of controlled substances and narcotics and this recommendation was forwarded to the treating health care provider and the Claimant.

Response Submitted by: Hoffman Kelley, 5316 Hwy. 290 West, Suite 360, Austin, TX 78735

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
January 18, 2011 March 3, 2011 April 1, 2011 August 4, 2011 September 7, 2011 November 1, 2011 January 9, 2012 February 20, 2012	Out-of-Pocket Expenses for Prescription Medications	$676.76	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for injured employees to pursue a medical fee dispute.
2. 28 Texas Administrative Code §133.305 sets out the procedures for the dispute sequence.
3. The services in dispute were denied by the respondent for the following reason:

   Denial letter dated March 8, 2012 states, "On 5/11/2010 a Peer Review was preformed to determine your treatment plan. It was determined at that time that no further treatment was reasonable or medically necessary. This included the weaning off of all medications. Based on these findings no further treatment of any kind will be covered on this work comp injury."

Issues

1. Did the requestor submit the out-of-pocket expenses for the services in dispute timely and in accordance with 28 Texas Administrative Code §133.307?
2. Are the dates of service eligible for review by Medical Fee Dispute Resolution?

Findings

1. In accordance with 28 Texas Administrative Code §133.307(c)(1)(B)(ii) which states that requests for medical dispute resolution (MDR) shall be filed in the form and manner prescribed by the Division. Requestors shall file two legible copies of the request with the Division. A requestor shall timely file with the Division's MDR Section or waive the right to MDR. The Division shall deem a request to be filed on the date the MDR Section receives the request. A request for medical fee dispute resolution that does not involve issues identified in subparagraph (B) of this paragraph shall be filed no later than one year after the date(s) of service in dispute. A request may be filed later than one year after the date(s) of service if a medical dispute regarding medical necessity has been filed, the medical fee dispute must be filed not later than 60 days after the date the requestor received the final decision on medical necessity, inclusive of all appeals, related to the health care in dispute and for which the carrier previously denied payment based on medical necessity. Dates of service January 18, 2011 through February 20, 2011 were denied as not medically necessary.

2. The requestor did not follow the dispute sequence in accordance with 28 Texas Administrative Code §133.305(b) which states that if a dispute regarding compensability, extent of injury, liability, or medical necessity exists for the same service for which there is a medical fee dispute, the disputes regarding compensability, extent of injury, liability, or medical necessity shall be resolved prior to the submission of a medical fee dispute for the same services in accordance with Labor Code §413.031 and §408.021. Therefore, the dates of service submitted on the DWC-60 Table of Disputed services are not eligible for review by Medical Fee Dispute Resolution.

Conclusion

For the reasons stated above, the division finds that the requestor has established that reimbursement is not due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	May 10, 2012 Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.